FORM B10 (Official Form 10) (Rev. 4/98)

United States Bankruptcy Court
61288, Houston TX 77208

SOUTHERN DISTRICT OF TEXAS P.O.Box
(Houston Division)

PROOF OF CLAIM

Name of Debtors

____Stage Stores, Inc., a Delaware corporation
____Specialty Retailers, Inc., a Texas corporation
____Specialty Retailers, Inc. (NV), a Nevada corporation

*place an "x" beside the name of the Debtor you are filing a claim against

Case Number

00-35078-H2-11
00-35079-H2-11
00-35080-H2-11

Creditor ID#: 788-37053

Name of Creditor (The person or other entity to whom the debtor owes money or property):

LAURENCE ROSENFIELD MD

__ **Check box if you are aware that anyone else a filed a proof of claim relating to your claim. Attach copy of statement giving particulars.**

Name and address where notices should be sent:

**********3-DIGIT 757
LAURENCE ROSENFIELD MD T1 P1
1100 E Lake Suite 370 ###***
Tyler TX 75701

__ **Check box if you have never received any notices from the bankruptcy court in this case**

__ **Check box if the address differs from the address on the envelope sent to you by the court.**

Account or other number by which creditor identifies debtor:

Check here if this claim __ replaces __ amends a previously filed claim, dated: _____

1. Basis for Claim

__ Goods sold
__ Services performed
__ Money loaned
__ Personal injury/wrongful death
__ Taxes
__ Other_____

__ Retiree benefits as defined in 11 U.S.C. § 1114(a)
__ Wages, salaries, and compensation (Fill out below)

Your SS#: _____ - _____ - _____

Unpaid compensation for services performed

from _____ (date) to _____ (date)

2. Date debt was incurred:

3. If court judgment, date obtained:

4. Total Amount of Claim at Time Case Filed: $ _____

If all or part of your claim is secured or entitled to priority, also complete Item 5 or 6 below.

___ Check this box if claim includes interest or other charges in addition to the principal amount of the claim. Attach itemized statement of all interest or additional charges.

5. Secured Claim.

__ Check this box if your claim is secured by collateral (including a right of setoff).

Brief Description of Collateral:
__ Real Estate __ Motor Vehicle
__ Other All personal and intangible property of Debtor's Estate

Value of Collateral: $ ____

Amount of arrearage and other charges at time case filed included in secured claim, if any $ _____

6. Unsecured Priority Claim.

__ Check this box if you have an unsecured priority claim
Amount entitled to priority $ _____
Specify the priority of the claim:

__ Wages, salaries, or commissions (up to $4,300),* earned within 90 days before filing of the bankruptcy petition or cessation of the debtor's business, whichever is earlier - 11 U.S.C. § 507(a)(3)
__ Contributions to an employee benefit plan - 11 U.S.C. § 507(a)(4).
__ Up to $1,950* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use - 11 U.S.C. § 507(a)(6).
__ Alimony, maintenance, or support owed to a spouse, former spouse, or child - 11 U.S.C. § 507(a)(7).
__ Taxes or penalties owed to governmental units - 11 U.S.C. § 507(a)(8).
__ Other – Specify applicable paragraph of 11 U.S.C. § 507(a-____).

Amounts are subject to adjustment on 4/1/98 and every 3 years thereafter with respect to cases commenced on or after the date of adjustment.

7. Credits: The amount of all payments on this claim has been credited and deducted for the purpose of making this proof of claim.

8. Supporting Documents: *Attach copies of supporting documents*, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, court judgments, mortgages, security agreements, and evidence of perfection of lien. DO NOT SEND ORIGINAL DOCUMENTS. If the documents are not available, explain. If the documents are voluminous, attach a summary.

9. Date-Stamped Copy: To receive an acknowledgment of the filing of your claim, enclose a stamped, self-addressed envelope and copy of this proof of claim.

This Space Is for Court Use Only

1134

Date	Sign and print the name and title, if any, of the creditor or other person authorized to file this claim (attach copy of power of attorney, if any):

Penalty for presenting fraudulent claim: Fine of up to $500,000 or imprisonment for up to 5 years, or both. 18 U.S.C. §§ 152 and 3571.

PLEASE DO NOT STAPLE IN THIS AREA

C2

[redacted]

STAGE STORES
10201 MAIN STREET
HOUSTON, TX 77025

APPROVED OMB-0938-0008

CARRIER

☐ ☐ PICA

HEALTH INSURANCE CLAIM FORM

PICA ☐ ☐

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)	
	456086274	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
LOEBIG BRENDA	11 08 53 M ☐ F ☒	STAGE STORES
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
PO BOX 363	Self ☐ Spouse ☐ Child ☐ Other ☒	506 BEALL BLVD
CITY / STATE	8. PATIENT STATUS	CITY / STATE
FRANKSTON TX	Single ☐ Married ☐ Other ☒	JACKSONVILLE TX
ZIP CODE / TELEPHONE (Include Area Code)	Employed ☐ Full-Time Student ☐ Part-Time Student ☐	ZIP CODE / TELEPHONE (INCLUDE AREA CODE)
75763 ( )528 4207		75766 ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
		456086274
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☒ YES ☐ NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX M ☐ F ☒
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX M ☐ F ☐	b. AUTO ACCIDENT? ☐ YES ☒ NO PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? ☐ YES ☒ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNATURE ON FILE 09 07 99

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNATURE ON FILE

SIGNED _____

14. DATE OF CURRENT: MM DD YY 05 07 99 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 04 17 00 TO 04 17 00
RAABE	G29173	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? ☐ YES ☒ NO $ CHARGES
ADJ:KELLY LEE AUTH SCS IMPLANT		
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
1. 354.4 CausalgiaUPPER LIM 3.		23. PRIOR AUTHORIZATION NUMBER
2. 719.44 PainHand 4.		

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 04 17 00	04 17 00	2	2	63650	58	1 2	1922 00	1				
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID / 30. BALANCE DUE
75 2798881 ☐ ☒	17542RO	☒ YES ☐ NO	$ 1922 00	$ 0 00 / $ 1922 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

LAURENCE ROSENFIELDMD
06 27 00
SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

NORTH PARKMFH
910 E HOUSTON 3RD FLOOR
TYLER TX 75702

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

LAURENCE ROSENFIELD MD
PO BOX 131980
TYLER TX 757031980

PIN# 604210 GRP# H7496

PHYSICIAN OR SUPPLIER INFORMATION

PATIENT AND INSURED INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

<<DOC>>
TRINITY MOTHER FRANCES HEALTH SYSTEM

Patient Name: LOEBIG, BRENDA S.
Case #: 170-15 Date:
92025080 04-17-00
Surgeon: Assistant/Co-Surgeon: Anesthesia:
LAWRENCE ROSENFIELD, M.D. Todd Raabe, M.D. Mark Roberts, M.D.

REPORT OF PROCEDURE

TITLE OF PROCEDURE: Spinal cord stimulator placement. Tunneling of electrode. Implantation of implantable pulse generator. Creation of subcutaneous bucket. The latter two by Dr. Raabe. See separate dictation.

ANESTHESIA: Monitored anesthesia care/heavy sedation/general.

ESTIMATED BLOOD LOSS: 10 cc.

DRAINS: None.

PREOPERATIVE DIAGNOSIS: Causalgia of right upper extremity, severe right upper extremity pain.

PROCEDURE IN DETAIL: After informed consent was obtained the patient was placed in the left lateral position on the x-ray, operating table in OR 1 at Trinity Mother Frances Hospital. Pressure points were padded. She was placed on the bean bag. After satisfactory sedation was achieved and full prep and drape was carried out, an antibiotic prophylaxis was given. The C7-T1 interspace was identified using fluoroscopy. Local anesthesia was infiltrated three fingerbreadths inferior to the C7-T1 interspace and a #15 Medtronic epidural needle was advanced into the C7-T1 interspace using _____ technique to air. AP and lateral view confirmed placement. Following this a lead blank was threaded up to C5 in the posterior ventral space and removed. Then a quad Pisces Medtronic epidural electrode, 56 centimeter., was threaded up the right side of the epidural space posteriorly to the C2-3 region. AP and lateral view confirmed proper placement. It took several manipulations of the catheter to get good stimulation just to the right upper extremity. All electrode combinations reproduced paresthesias to the right upper extremity which was covering her painful dermatomes.

Following this the needle was removed from the spinal canal but left deep in the subcutaneous tissue. Dr. Raabe took over at this point to anchor the electrodes and tunnel them. A subcutaneous pocket was made in the right lower quadrant. See separate dictation for anchoring of electrode. All connections were tightened. A silicon boot was placed. An Itrel III, IPG was placed into the pocket. Impedance was checked. The wounds were closed in two layers. See separate dictation by Dr. Raabe for other details.

The patient tolerated the procedure well. She will be followed up in the office in approximately ten days.

_____, M.D.
LAWRENCE ROSENFIELD, M.D.

LR/prn#21
D: 04-17-00 T: 04-18-00
<<FAXTO 500, 366>>
<<ENDLIST>>
cc: East Texas Neurology

<<DOC>>
TRINITY/MOTHER FRANCES HEALTH SYSTEM

Patient Name:	LOEBIG, BRENDA	
Case No. #:	Room No	Date
92025080	170-15	04/17/00
Surgeon	Assistant	Anesthesiologist
T. RAABE, M.D.	L. ROSENFIELD, M.D.	

REPORT OF OPERATION

PREOPERATIVE DIAGNOSIS: Reflux sympathetic dystrophy, right upper extremity.

POSTOPERATIVE DIAGNOSIS: Same.

OPERATION: IMPLANTATION OF PULSE GENERATOR FOR SPINAL CORD STIMULATOR.

ANESTHESIA: Local with sedation.

SUMMARY: The patient was taken to the operating room where she was sedated. She was turned to the left lateral decubitus position and her neck, back, and right flank were prepped and draped in the usual sterile fashion. Local anesthesia was accomplished and the spinal cord stimulator lead was placed at the C2-C3 level by Dr. Rosenfield under fluoroscopic control- that portion of the up will be dictated separately. Once in place, the lead was anchored to the fascia using a standard lead anchor and three interrupted O silk ligatures.

An accessory incision was made over the right side of the low back measuring approximately 2-3 cm. A shunt passer was utilized to place the spinal cord stimulator lead from the cephalad to the caudad incision. At this point, a transverse incision was made over the right side of the abdomen and a subcutaneous pocket was created. A passer was utilized to retrieve the spinal cord pulse generator lead from the pocket and pass it in retrograde fashion to the intermediate incision over the right side of the low back. The leads were then dried and the extension was connected to the spinal cord stimulator lead using standard technique. A silicone sleeve was placed over the connection and secured with two interrupted O silk sutures to provide water tight closure. The extension was then connected back to the pulse generator in standard fashion. The small amount of the lead was coiled beneath the pulse generator and the generator was placed in the subcutaneous pocket.

The wounds were irrigated with copious amounts of normal saline. All obvious bleeding points were controlled. Some slack was left in the lead

CONTINUED ON NEXT PAGE

TRINITY/MOTHER FRANCES HEALTH SYSTEM

Patient Name: LOEBIG, BRENDA		
Case No. #:	Room No	Date
92025080		04/17/00
Surgeon	Assistant	Anesthesiologist
T. RAABE, M.D.	L. ROSENFIELD, M.D.	

at about the neck to allow for cervical motion. The subcutaneous tissues were then approximated with interrupted O Vicryl and the skin was closed with running Monocril subcuticular. The wounds were dressed with Benzoin and Steri-strips, dressing, sponge, and tape.

The patient tolerated the procedure well and was returned to the recovery room in stable condition. Sponge, needle, and instrument counts were correct at conclusion of the procedure. There were no apparent intraoperative complications.

_____ M.D.
TODD RAABE, M.D.

TR/prn#18
D: 04/18/00 T: 04/18/00
<<FAXTO 386>>
<<ENDLIST>>

PLEASE DO NOT STAPLE IN THIS AREA

C6

[redacted]

STAGE STORES
10201 MAIN STREET
HOUSTON, TX 77025

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE [ ] MEDICAID [ ] CHAMPUS [ ] CHAMPVA [ ] GROUP HEALTH PLAN [ ] FECA BLK LUNG [ ] OTHER [ ]
(Medicare #) (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 456086274

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): LOEBIG BRENDA

3. PATIENT'S BIRTH DATE MM DD YY: 11 08 53 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): STAGE STORES

5. PATIENT'S ADDRESS (No., Street): PO BOX 363

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [X]

7. INSURED'S ADDRESS (No., Street): 506 BEALL BLVD

CITY: FRANKSTON — STATE: TX

8. PATIENT STATUS: Single [ ] Married [ ] Other [X]

CITY: JACKSONVILLE — STATE: TX

ZIP CODE: 75763 — TELEPHONE (Include Area Code): ( ) 528 4207

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: 75766 — TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 456086274

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) [X] YES [ ] NO

a. INSURED'S DATE OF BIRTH MM DD YY: — SEX M [ ] F [X]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? [ ] YES [X] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE:

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [ ] NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNATURE ON FILE

SIGNED _____ DATE 09 07 99

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNATURE ON FILE

SIGNED _____

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY: 05 07 99

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY:

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM — TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: RAABE

17a. I.D. NUMBER OF REFERRING PHYSICIAN: G29173

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM — TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? [ ] YES [X] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 354.4 CausalgiaUPPER LIM
2. 337.21 Reflex Sympath Dy
3.
4.

22. MEDICAID RESUBMISSION CODE: — ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER:

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 06 12 00	06 12 00	11	1	95970		1 2	75 00	1				
2 06 12 00	06 12 00	11	1	99212		1 2	40 00	1				
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN: 75 2798881 [ ] [X]

26. PATIENT'S ACCOUNT NO.: 17542RO

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] NO

28. TOTAL CHARGE: $ 115 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 115 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

LAURENCE ROSENFIELD MD

SIGNED 06 27 00 DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

SAME

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

LAURENCE ROSENFIELD MD
PO BOX 131980
TYLER TX 757031980

PIN# ND4210 GRP# H7496

PATIENT AND INSURED INFORMATION — CARRIER

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

EAST TEXAS NEUROLOGY, LLC

Richard F. Ulrich, M.D. * Preston E. Harrison, M.D. *
Wayne E. Hostetler, M.D. * Laurence Rosenfield, M.D. +
Robert F. Burton, MD *

* Board Certified by the American College of Psychiatry/Neurology
+ Diplomate American Board of Anesthesiology
+ Diplomate American Board of Pain Medicine
+ Diplomate American Board of Pain Management

June 12, 2000

RE: BRENDA LOEBIG

Brenda Loebig returned to the office today, 1½ months since her last visit. She still has stimulation paresthesias. She uses her SCS during the day and turns it off at night as she sleeps fairly well without it. She has stimulation paresthesias to both arms, but this is much stronger on the right, which is where she needs it. It goes from her neck to her finger tips, with the strongest stimulation felt in the distal arm where she needs it. She now has better use of her shoulder, can use overhead reaching. She has significant improvement in hand pain, approximately 50%.

She rates her pain as a 6 with a range of 6 to 9. She continues to work full-time light duty.

Objectively, she is 5'-0", weighs 149 lbs, BP: 150/80, P: 60, R: 20. She still has a CRPS-II type picture with some nail changes and some skin changes, significant edema, but no hyperhidrosis. She has very little movement of her fingers. MPJ and IPJ have markedly limited ROM. Wrist movement is likewise markedly limited to a total of 40° between flexion and extension. Her shoulder, however, is doing quite well, and her elbow has a full ROM. Pronation and supination is limited to about ¾ of normal.

She continues to take Vicodin 2 tablets a day and Neurontin 300 mg q.hs. We will continue these.

Her SCS was analyzed today. She has amplitude limits of 3.5V down to -0-, pulse width of 300 microseconds down to 60. She tends to keep the rate at about 45. Her current voltage is 2.2. She has cycling mode of 1 minute on and 1 minute off. We still have the same electrode configuration of 1-, case +, unipolar stimulation.

IMPRESSION:
1. CRPS-II; status post SCS implant with good result.

SUGGESTIONS:
1. Refill Vicodin and Neurontin today.
2. She will follow-up monthly for refills; she will follow-up with me in 3 months.

Laurence Rosenfield, M.D. LR/kh

1100 E. Lake Street, #370 Tyler, Texas 75701
TELEPHONE: (903) 597-3787 FAX: (903) 593-4052* or 595-1549+

FORM B9F (ALT.) (Chapter 11 Corporation/Partnership Case) (9/97)

UNITED STATES BANKRUPTCY COURT — Southern District of Texas

Notice of Chapter 11 Bankruptcy Case, Meeting of Creditors, & Deadlines

A chapter 11 bankruptcy case concerning each of the debtor corporations listed below was filed on June 1, 2000

You may be a creditor of one or more of the debtor(s), **This notice lists important deadlines.** You may want to consult an attorney to protect your rights. All documents filed in the cases may be inspected at the bankruptcy clerk's office at the address listed below. NOTE: The staff of the bankruptcy clerk's office cannot give legal advice.

See Reverse Side For Important Explanations.

Debtor (name(s), case numbers and address):	Jointly Administered Under Case Number 00-35078-H2-11
Stage Stores, Inc., a Delaware corp.; Case No. 00-35078-H2-11 Specialty Retailers, Inc., a Texas corp.; Case No. 00-35079-H2-11 Specialty Retailers, Inc. (NV), a Dallas corp.; Case No. 00-35080-H2-11 10210 Main Street Houston, TX 77025-5229 **Toll Free Number: 1-800-804-2013 (for case information)**	Taxpayer ID Nos: 76-0407711 (Stage Stores, Inc.) 74-0821900 (Specialty Retailers, Inc.) 91-1826900 (Specialty Retailers, Inc. (NV))
Attorney for Debtors (name and address): Andrew E. Jillson, Esq. Lynnette R. Warman, Esq. Jenkens & Gilchrist, a Professional corporation 1445 Ross Avenue, Suite 3200 Dallas, TX 75202-2799	Attorneys for Debtors Telephone Number: Toll Free 1-877-559-9672 **Information may also be obtained from the following website:** Website address: www.stagestoresbankruptcy.com

Meeting of Creditors

Date: 7 / 11 / 00 Time: 2:00 ( ) A.M. (X) P.M. Location: U.S. Courthouse, Jury Assembly Room, 515 Rusk, 6th Floor, Houston, Texas 77002

Deadlines to File a Proof of Claim

Proofs of Claim must be *received* by the bankruptcy clerk's office by the following deadline:

For all creditors (except a governmental unit): 10/9/00 For a governmental unit: 11/28/00

Mail claim to: U.S. Bankruptcy Court, P.O. Box 61288, Houston, TX 77208

Creditors May Not Take Certain Actions:

The filing of the bankruptcy case automatically stays certain collection and other actions against the debtor and the debtor's property. If you attempt to collect a debt or take other action in violation of the Bankruptcy Code, you may be penalized.

Address of the Bankruptcy Clerk's Office: 515 Rusk Avenue 1st Floor Houston, Texas 77002 Telephone number: 713/250-5115	For the Court: Clerk of the Bankruptcy Court: Michael N. Milby, Clerk
Hours Open: 9:00 a.m. - 4:30 p.m.	Date:

DALLAS1 592549v1 48909-00001